State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–2476/1 P1
PJK:...
KMG

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

Draft 4/18 Friday AM possible or 4/21

AN ACT ...; **relating to:** transferring administration of the Health Insurance Risk–Sharing Plan from the Department of Health and Family Services to the Office of the Commissioner of Insurance, making various miscellaneous changes to that plan, and granting rule–making authority.

Analysis by the Legislative Reference Bureau

This draft will be converted to an amendment to the budget.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.145 (5) (title) of the statutes is created to read:

20.145 **(5)** (title) HEALTH INSURANCE RISK–SHARING PLAN ADMINISTRATION.

SECTION 2. 20.435 (4) (af) of the statutes is renumbered 20.145 (5) (af) and amended to read:

20.145 **(5)** (af) ~~*Health insurance risk–sharing plan; transfer*~~ *Transfer to fund for costs.* The amounts in the schedule to be paid into the ~~health insurance~~

~~risk–sharing plan~~ Health Insurance Risk–Sharing Plan fund for paying a portion of the operating costs of the ~~health insurance risk–sharing plan~~ Health Insurance Risk–Sharing Plan under ~~ch. 149~~ subch. II of ch. 619.

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293; 1999 a. 5, 9, 32, 52, 84, 103, 109, 113, 133, 185, 186; 2001 a. 16, 69, 103, 105.

SECTION 3. 20.435 (4) (ah) of the statutes is renumbered 20.145 (5) (ah) and amended to read:

20.145 **(5)** (ah) ~~*Health insurance risk–sharing plan; transfer*~~ *Transfer to fund for premium and deductible reduction subsidy.* Biennially, the amounts in the schedule to be paid into the ~~health insurance risk–sharing plan~~ Health Insurance Risk–Sharing Plan fund for the purpose of subsidizing premium reductions under s. ~~149.165~~ 619.165 and deductible reductions under s. ~~149.14~~ 619.14 (5) (a).

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293; 1999 a. 5, 9, 32, 52, 84, 103, 109, 113, 133, 185, 186; 2001 a. 16, 69, 103, 105.

SECTION 4. 20.435 (4) (u) of the statutes is renumbered 20.145 (5) (u) and amended to read:

20.145 **(5)** (u) ~~*Health insurance risk–sharing plan; administration*~~ *Administration.* Biennially, from the ~~health insurance risk–sharing plan~~ Health Insurance Risk–Sharing Plan fund, the amounts in the schedule for the administration of ~~ch. 149~~ subch. II of ch. 619, subject to s. ~~149.143~~ 619.143 (2m).

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293; 1999 a. 5, 9, 32, 52, 84, 103, 109, 113, 133, 185, 186; 2001 a. 16, 69, 103, 105.

SECTION 5. 20.435 (4) (v) of the statutes is renumbered 20.145 (5) (v) and amended to read:

20.145 **(5)** (v) ~~*Health insurance risk–sharing plan; program*~~ *Program benefits.* All moneys received by the ~~health insurance risk–sharing plan~~ Health Insurance Risk–Sharing Plan fund, except for moneys appropriated under par. (u), for the operating costs of the ~~health insurance risk–sharing plan~~ Health Insurance Risk–Sharing Plan under ~~ch. 149~~ subch. II of ch. 619, subject to s. ~~149.143~~ 619.143 (2m).

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293; 1999 a. 5, 9, 32, 52, 84, 103, 109, 113, 133, 185, 186; 2001 a. 16, 69, 103, 105.

SECTION 6. 25.55 (1) of the statutes is amended to read:

25.55 **(1)** All moneys appropriated under s. ~~20.435 (4)~~ 20.145 (5) (af).

History: 1999 a. 9.

SECTION 7. 25.55 (2) of the statutes is amended to read:

25.55 **(2)** All moneys appropriated under s. ~~20.435 (4)~~ 20.145 (5) (ah).

History: 1999 a. 9.

SECTION 8. 25.55 (3) of the statutes is amended to read:

25.55 **(3)** Insurer and drug manufacturer and distributor assessments under ~~ch. 149~~ subch. II of ch. 619.

History: 1999 a. 9.

SECTION 9. 25.55 (4) of the statutes is amended to read:

25.55 **(4)** Premiums paid by eligible persons under ~~ch. 149~~ subch. II of ch. 619.".

History: 1999 a. 9.

SECTION 10. 71.65 (4) of the statutes is amended to read:

71.65 **(4)** SELF–INSURERS. A person who is required to file an annual withholding report under sub. (3) (a) and who is a self–insurer for the purposes of ~~ch.~~

~~149~~ subch. II of ch. 619 shall indicate on the return that the person is such a self–insurer.

SEC. #. Chapter 149 (title) of the statutes is repealed.

History: 1987 a. 312; 1991 a. 39; 1993 a. 112; 1997 a. 27, 291.

SECTION 11. 149.10 (intro.) of the statutes is renumbered 619.10 (intro.) and amended to read:

619.10 Definitions. (intro.) In this ~~chapter~~ subchapter:

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38.

SECTION 12. 149.10 (2) of the statutes is renumbered 619.10 (2) and amended to read:

619.10 **(2)** "Board" means the board of governors established under s. ~~149.15~~ 619.15.

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38.

SECTION 13. 149.10 (2c) of the statutes is renumbered 619.10 (2c).

SECTION 14. 149.10 (2f) of the statutes is repealed.

SECTION 15. 149.10 (2j) of the statutes is renumbered 619.10 (2j).

SECTION 16. 149.10 (2m) of the statutes is repealed.

SECTION 17. 149.10 (2t) of the statutes is renumbered 619.10 (2t).

SECTION 18. 149.10 (3) of the statutes is renumbered 619.10 (3) and amended to read:

619.10 **(3)** "Eligible person" means a resident ~~of this state~~ who qualifies under s. ~~149.12~~ 619.12 whether or not the person is legally responsible for the payment of medical expenses incurred on the person's behalf.

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38.

SECTION 19. 149.10 (3c) of the statutes is renumbered 619.10 (3c).

SECTION 20. 149.10 (3d) of the statutes is renumbered 619.10 (3d).

SECTION 21. 149.10 (3e) of the statutes is renumbered 619.10 (3e).

SECTION 22. 149.10 (3g) of the statutes is renumbered 619.10 (3g).

SECTION 23. 149.10 (3j) of the statutes is renumbered 619.10 (3j).

SECTION 24. 149.10 (3m) of the statutes is renumbered 619.10 (3m).

****NOTE: See s. 149.13 (2). Insurers are assessed on the basis of their "health care coverage revenue." Do you want that to remain the same? Is the definition in this subsection for "health care coverage revenue" fine for that? Do you want something comparable to "health care coverage revenue" for drug manufacturers and, if so, what?

SECTION 25. 149.10 (4) of the statutes is renumbered 619.10 (4).

SECTION 26. 149.10 (4c) of the statutes is renumbered 619.10 (4c).

SECTION 27. 149.10 (4m) of the statutes is renumbered 619.10 (4m).

SECTION 28. 149.10 (4p) of the statutes is repealed.

SECTION 29. 149.10 (5) of the statutes is renumbered 619.10 (5).

SECTION 30. 149.10 (5m) of the statutes is renumbered 619.10 (5m).

SECTION 31. 149.10 (6) of the statutes is renumbered 619.10 (6).

SECTION 32. 149.10 (7) of the statutes is renumbered 619.10 (7).

SECTION 33. 149.10 (8) of the statutes is renumbered 619.10 (8) and amended to read:

619.10 **(8)** "Plan" means the health care insurance plan established and administered under this ~~chapter~~ subchapter.

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38.

SECTION 34. 149.10 (8b) of the statutes is repealed.

SECTION 35. 149.10 (8c) of the statutes is repealed.

SECTION 36. 149.10 (8j) of the statutes is renumbered 619.10 (8j).

SECTION 37. 149.10 (8m) of the statutes is renumbered 619.10 (8m).

SECTION 38. 149.10 (8p) of the statutes is repealed.

SECTION 39. 149.10 (9) of the statutes is renumbered 619.10 (9) and amended to read:

619.10 **(9)** "Resident" means a person who has been legally domiciled in this state for a period of at least 30 days or, with respect to an eligible individual, an individual who resides in this state. For purposes of this ~~chapter~~ subchapter, legal domicile is established by living in this state and obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child's parents or the child's guardian is legally domiciled in this state. A person with a developmental disability or another disability ~~which~~ that prevents the person from obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return, is legally domiciled in this state by living in this state.

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38.

SECTION 40. 149.10 (10) of the statutes is repealed.

SECTION 41. 149.10 (11) of the statutes is renumbered 619.10 (11).

SECTION 42. 149.11 of the statutes is renumbered 619.11 and amended to read:

619.11 Operation of plan. The ~~department~~ board shall promulgate rules for the design and operation of a plan of health insurance coverage for an eligible person ~~which~~ that satisfies the requirements of this ~~chapter~~ subchapter.

History: 1979 c. 313; 1997 a. 27 s. 4825; Stats. 1997 s. 149.11.

SECTION 43. 149.115 of the statutes is renumbered 619.115 and amended to read:

619.115 Rules relating to creditable coverage. The commissioner, ~~in consultation with the department,~~ shall promulgate rules that specify how creditable coverage is to be aggregated for purposes of s. ~~149.10~~ 619.10 (2t) (a) and

that determine the creditable coverage to which s. ~~149.10~~ 619.10 (2t) (b) and (d) applies. The rules shall comply with section 2701 (c) of P.L. 104–191.

History: 1997 a. 27 s. 4825f; 1997 a. 237; 2001 a. 16.

SECTION 44. 149.12 of the statutes is renumbered 619.12, and 619.12 (3) (c), as renumbered, is amended to read:

619.12 **(3)** (c) The ~~department~~ board may promulgate rules specifying other deductible or coinsurance amounts that, if paid or reimbursed for persons, will not make the persons ineligible for coverage under the plan.

Sec. # RN; 149.13 (title); 619.13 (title)

History: 1979 c. 313; 1983 a. 27, 215; 1985 a. 29, 73; 1987 a. 27, 70, 239; 1989 a. 201 s. 36; 1989 a. 332, 359; 1991 a. 39, 250; 1993 a. 27; 1995 a. 27, 407; 1997 a. 27 ss. 3025f, 4826 to 4831e; Stats. 1997 s. 149.12; 1999 a. 9.

SECTION 45. 149.13 (1) of the statutes is renumbered 619.13 (1) and amended to read:

that

619.13 **(1)** Every insurer shall participate in the cost of administering the plan, except the commissioner may by rule exempt as a class those insurers whose share as determined under sub. (2) would be so minimal as to not exceed the estimated cost of levying the assessment. ~~The commissioner shall advise the department of the insurers participating in the cost of administering the plan.~~

History: 1979 c. 313; 1981 c. 83; 1981 c. 314 s. 146; 1985 a. 29; 1989 a. 187 s. 29; 1991 a. 39, 269; 1997 a. 27 ss. 4834 to 4838; Stats. 1997 s. 149.13; 2001 a. 16.

****NOTE: Should the last sentence be stricken or do you instead want to retain the last sentence but change "department" to "board"?

History: 1979 c. 313; 1981 c. 83; 1981 c. 314 s. 146; 1985 a. 29; 1989 a. 187 s. 29; 1991 a. 39, 269; 1997 a. 27 ss. 4834 to 4838; Stats. 1997 s. 149.13; 2001 a. 16.

SECTION 46. 149.13 (2) of the statutes is repealed.

SECTION 47. 149.13 (3) of the statutes is renumbered 619.13 (3) and amended to read:

619.13 **(3)** (a) Each insurer's proportion of participation under sub. (2) shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner. The commissioner shall assess an insurer for the insurer's proportion of participation ~~based on the total assessments estimated by the department under s. 149.143 (2) (a) 3.~~

(b) If the ~~department~~ board or the commissioner finds that the commissioner's authority to require insurers to report under chs. 600 to 646 and 655 is not adequate to permit the ~~department, the~~ commissioner or the board to carry out the ~~department's,~~ commissioner's or board's responsibilities under this ~~chapter~~ subchapter, the commissioner shall promulgate rules requiring insurers to report the information necessary for the ~~department,~~ commissioner and board to make the determinations required under this ~~chapter~~ subchapter.

History: 1979 c. 313; 1981 c. 83; 1981 c. 314 s. 146; 1985 a. 29; 1989 a. 187 s. 29; 1991 a. 39, 269; 1997 a. 27 ss. 4834 to 4838; Stats. 1997 s. 149.13; 2001 a. 16.

SECTION 48. 149.13 (4) of the statutes is repealed.

SECTION 49. 149.14 (title) of the statutes is renumbered 619.14 (title).

SECTION 50. 149.14 (1) of the statutes is renumbered 619.14 (1).

SECTION 51. 149.14 (2) of the statutes is renumbered 619.14 (2).

SECTION 52. 149.14 (3) (intro.) of the statutes is renumbered 619.14 (3) and amended to read:

619.14 **(3)** COVERED EXPENSES. Except as ~~provided in sub. (4), except as~~ restricted by cost containment provisions under s. ~~149.17~~ 619.17 (4) and except as reduced by the ~~department~~ board under ss. ~~149.143~~ 619.143 and ~~149.144~~ 619.144, covered expenses for the coverage under this section shall be the payment rates established ~~by the department~~ under s. ~~149.142~~ 619.142 for the services provided by persons licensed under ch. 446 and certified under s. 49.45 (2) (a) 11. Except as ~~provided in sub. (4), except as~~ restricted by cost containment provisions under s. ~~149.17~~ 619.17 (4) and except as reduced by the ~~department~~ board under ss. ~~149.143~~ 619.143 and ~~149.144~~ 619.144, covered expenses for the coverage under this section shall also be the payment rates established ~~by the department~~ under s. ~~149.142~~ 619.142 for the ~~following~~ services and articles specified by the board if the service or article is prescribed by a physician who is licensed under ch.

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and 619.14 (1) (b), as renumbered, is amended to read:

448 or in another state and who is certified under s. 49.45 (2) (a) 11. and if the service or article is provided by a provider certified under s. 49.45 (2) (a) 11.÷

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

SECTION 53. 149.14 (3) (a) to (r) of the statutes are repealed.

SECTION 54. 149.14 (4) of the statutes is repealed.

SECTION 55. 149.14 (4c) of the statutes is repealed.

SECTION 56. 149.14 (4m) of the statutes is renumbered 619.14 (4) and amended to read:

619.14 **(4)** PAYMENT IS PAYMENT IN FULL. Except for copayments, coinsurance, or deductibles required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under ss. ~~149.142, 149.143, and 149.144~~ 619.142, 619.143, and 619.144 and may not bill an eligible person who receives the service or article for any amount by which the charge for the service or article is reduced under s. ~~149.142, 149.143, or 149.144~~ 619.142, 619.143, or 619.144.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

SECTION 57. 149.14 (5) of the statutes is renumbered 619.14 (5), and 619.14 (5) (a), (d) and (e), as renumbered, are amended to read:

619.14 **(5)** (a) The plan shall offer a deductible in combination with appropriate premiums determined under this ~~chapter~~ subchapter for major medical expense coverage required under this section. For coverage offered to those persons eligible for ~~medicare~~ Medicare, the plan shall offer a deductible equal to the deductible charged by part A of title XVIII of the federal ~~social security act~~ Social Security Act, as amended. The deductible amounts for all other eligible persons shall be dependent upon household income as determined under s. ~~149.165~~ 619.165. For eligible persons under s. ~~149.165~~ 619.165 (2) (a) 1., the deductible shall be $500. For

eligible persons under s. ~~149.165~~ 619.165 (2) (a) 2., the deductible shall be $600. For eligible persons under s. ~~149.165~~ 619.165 (2) (a) 3., the deductible shall be $700. For eligible persons under s. ~~149.165~~ 619.165 (2) (a) 4., the deductible shall be $800. For all other eligible persons who are not eligible for ~~medicare~~ Medicare, the deductible shall be $1,000. With respect to all eligible persons, expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

(d) Notwithstanding pars. (a) to (c), the ~~department~~ board may establish different deductible amounts, a different coinsurance percentage, and different covered costs and deductible aggregate amounts from those specified in pars. (a) to (c) in accordance with cost containment provisions established by the ~~department~~ board under s. ~~149.17~~ (4).

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

(e) ~~Subject to sub. (8) (b), the department~~ board may, by rule under s. ~~149.17~~ (4), establish for prescription drug coverage under ~~sub. (3) (d)~~ this section copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which the plan will pay 100% of covered costs ~~under sub. (3) (d). Any copayment amount, coinsurance rate, or out–of–pocket limit established under this paragraph is subject to the approval of the board.~~ Copayments and coinsurance paid by an eligible person under this paragraph ~~are~~ shall be separate from and ~~do~~ may not count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

SECTION 58. 149.14 (5m) of the statutes is renumbered 619.14 (5m), and 619.14 (5m) (c), as renumbered, is amended to read:

619.14 **(5m)** (c) Other economic factors that the ~~department and the~~ board ~~consider~~ considers relevant.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

SECTION 59. 149.14 (6) of the statutes is renumbered 619.14 (6).

SECTION 60. 149.14 (7) of the statutes is renumbered 619.14 (7), and 619.14 (7) (b) and (c), as renumbered, are amended to read:

619.14 **(7)** (b) The ~~department~~ board has a cause of action against an eligible ~~participant~~ person for the recovery of the amount of benefits paid ~~which~~ that are not for covered expenses under the plan. Benefits under the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

(c) The ~~department~~ board is subrogated to the rights of an eligible person to recover special damages for illness or injury to the person caused by the act of a 3rd person to the extent that benefits are provided under the plan. Section 814.03 (3) applies to the ~~department~~ board under this paragraph.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

SECTION 61. 149.14 (8) of the statutes is repealed.

SECTION 62. 149.142 of the statutes is renumbered 619.142 and ~~619.142 (1) (a)~~ and (b), as renumbered, are amended to read:

619.142 **(1)** (a) Except as provided in par. (b), the ~~department~~ board, in consultation with the department of health and family services, shall establish payment rates for covered expenses that consist of the allowable charges paid under s. 49.46 (2) for the services and articles provided plus an enhancement determined by the ~~department~~ board. The rates shall be based on the allowable charges paid under s. 49.46 (2), projected plan costs and trend factors. Using the same methodology that applies to ~~medical assistance~~ Medical Assistance under subch. IV

of ch. 49, the ~~department~~ board shall establish hospital outpatient per visit reimbursement rates and hospital inpatient reimbursement rates that are specific to diagnostically related groups of eligible persons.

History: 1999 a. 9; 2001 a. 16.

(b) The payment rate for a prescription drug shall be the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. ~~149.17~~ (4), the ~~department~~ board may not reduce the payment rate for prescription drugs below the rate specified in this paragraph, and the rate may not be adjusted under s. ~~149.143 or 149.144~~.

History: 1999 a. 9; 2001 a. 16.

SECTION 63. 149.143 of the statutes is renumbered 619.143, and 619.143 (1) (intro.), (a) and (b) 1. a., c. and d. and 2. a. and b., (2) (a) (intro.), 1. a., 2., 3. and 4. and (b), (2m) (a) 2. and (b) 1., 2. and 3., (3) (a) and (b), (3m), (4) and (5) (a) and (b), as renumbered, are amended to read:

619.143 **(1)** (intro.) The ~~department~~ commissioner shall pay or recover the operating costs of the plan from the appropriation under s. ~~20.435 (4)~~ 20.145 (5) (v) and administrative costs of the plan from the appropriation under s. ~~20.435 (4)~~ 20.145 (5) (u). For purposes of determining premiums, insurer and drug manufacturer and distributor assessments, and provider payment rate adjustments, the ~~department~~ board shall apportion and prioritize responsibility for payment or recovery of plan costs from among the moneys constituting the fund as follows:

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(a) First from the moneys transferred to the fund from the appropriation account under s. ~~20.435 (4)~~ 20.145 (5) (af).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(b) 1. a. First, from premiums from eligible persons with coverage under s. ~~149.14~~ 619.14 (2) (a) set at a rate that is 140% to 150% of the rate that a standard

risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. ~~149.14~~ 619.14 (2) (b) set in accordance with s. ~~149.14~~ 619.14 (5m), including amounts received for premium and deductible subsidies under s. ~~149.144~~ 619.144 and under the transfer to the fund from the appropriation account under s. ~~20.435 (4)~~ 20.145 (5) (ah), and from premiums collected from eligible persons with coverage under s. ~~149.146~~ 619.141 set in accordance with s. ~~149.146~~ 619.141 (2) (b).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

c. Third, by increasing premiums from eligible persons with coverage under s. ~~149.14~~ 619.14 (2) (a) to more than the rate at which premiums were set under subd. 1. a. but not more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. ~~149.14~~ 619.14 (2) (b) by a comparable amount in accordance with s. ~~149.14~~ 619.14 (5m), including amounts received for premium and deductible subsidies under s. ~~149.144~~ 619.144 and under the transfer to the fund from the appropriation account under s. ~~20.435 (4)~~ 20.145 (5) (ah), and by increasing premiums from eligible persons with coverage under s. ~~149.146~~ 619.141 in accordance with s. ~~149.146~~ 619.141 (2) (b), to the extent that the amounts under subd. 1. a. and b. are insufficient to pay 60% of plan costs.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

d. Fourth, notwithstanding subd. 2., by increasing insurer assessments, excluding assessments under s. ~~149.144~~ 619.144, increasing drug manufacturer and drug distributor assessments, excluding assessments under s. 619.144, and adjusting provider payment rates, subject to s. ~~149.142~~ 619.142 (1) (b) and excluding

adjustments to those rates under s. ~~149.144~~ 619.144, in equal proportions and to the extent that the amounts under subd. 1. a. to c. are insufficient to pay 60% of plan costs.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

2. a. ~~Fifty percent~~ One–third from insurer assessments, excluding assessments under s. ~~149.144~~ 619.144.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

b. ~~Fifty percent~~ One–third from adjustments to provider payment rates, subject to s. ~~149.142~~ 619.142 (1) (b) and excluding adjustments to those rates under s. ~~149.144~~ 619.144.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(2) (a) (intro.) Prior to each plan year, the ~~department~~ board shall estimate the operating and administrative costs of the plan and the costs of the premium reductions under s. ~~149.165~~ 619.165 and the deductible reductions under s. ~~149.14~~ 619.14 (5) (a) for the new plan year and do all of the following:

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

1. a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set at a level sufficient, when including amounts received for premium and deductible subsidies under s. ~~149.144~~ 619.144 and under the transfer to the fund from the appropriation account under s. ~~20.435 (4)~~ 20.145 (5) (ah) and from premiums collected from eligible persons with coverage under s. ~~149.146~~ ~~619.146~~ set in accordance with s. ~~149.146~~ ~~619.146~~ (2) (b), to cover 60% of the estimated plan costs for the new plan year, after deducting from the estimated plan costs the amount available for transfer to the fund from the appropriation account under s. ~~20.435 (4)~~ 20.145 (5) (af) for that plan year.

619.141

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

2. After making the determinations under subd. 1., by rule set premium rates for the new plan year, including the rates under s. ~~149.146~~ ~~619.146~~ (2) (b), in the

manner specified in sub. (1) (b) 1. a. and c. and such that a rate for coverage under s. ~~149.14~~ 619.14 (2) (a) is ~~approved by the board and is~~ not less than 140% nor more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

3. By rule set the total insurer assessments under s. ~~149.13~~ 619.13 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. a. and notify the commissioner of the amount.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

4. By the same rule as under ~~subd. 3.~~ subds. 3. and 3m., adjust the provider payment rate for the new plan year, subject to s. ~~149.142~~ 619.142 (1) (b), by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. b. and as provided in s. ~~149.145~~ 619.145.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(b) In setting the premium rates under par. (a) 2., the insurer assessment amount under par. (a) 3., the drug manufacturer and drug distributor assessment amount under par. (a) 3m., and the provider payment rate under par. (a) 4. for the new plan year, the ~~department~~ board shall include any increase or decrease necessary to reflect the amount, if any, by which the rates and amount set under par. (a) for the current plan year differed from the rates and amount which would have equaled the amounts specified in sub. (1) (b) in the current plan year.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(2m) (a) (intro.) The ~~department~~ board shall keep a separate accounting of the difference between the following:

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

2. The amount of premiums, including amounts received for premium and deductible subsidies, necessary to cover 60% of the plan costs for the plan year, after deducting the amount transferred to the fund from the appropriation account under s. ~~20.435 (4)~~ 20.145 (5) (af).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(b) 1. To reduce premiums in succeeding plan years as provided in sub. (1) (b) 1. b. For eligible persons with coverage under s. ~~149.14~~ 619.14 (2) (a), premiums may not be reduced below 140% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

2. For other needs of eligible persons~~, with the approval of the board~~.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

3. For distribution to eligible persons, notwithstanding any requirements in this ~~chapter~~ subchapter related to setting premium amounts. The ~~department~~ board, with the ~~approval of the board and the~~ concurrence of the plan actuary, shall determine the policies, eligibility criteria, methodology, and other factors to be used in making any distribution under this subdivision.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(3) (a) If, during a plan year, the ~~department~~ board determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer and drug manufacturer and drug distributor assessments and the provider payment rate under s. ~~149.144~~ 619.144 will not be sufficient to cover plan costs, the ~~department~~ board may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. ~~149.146~~ 619.141 (2) (b) and the maximum specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3. and 3m. for the remainder of the

plan year, subject to sub. (1) (b) 2. a. and am., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (b) 2. b. and s. ~~149.142~~ 619.142 (1) (b).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(b) If the ~~department~~ board increases premium rates and insurer and drug manufacturer and drug distributor assessments and adjusts the provider payment rate under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the ~~department~~ board may further adjust, in equal proportions, assessments set under sub. (2) (a) 3. and 3m. and the provider payment rate set under sub. (2) (a) 4., without regard to sub. (1) (b) 2. but subject to s. ~~149.142~~ 619.142 (1) (b).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(3m) Subject to s. ~~149.14~~ 619.14 (4m), insurers, drug manufacturers, drug distributors, and providers may recover in the normal course of their respective businesses without time limitation assessments or provider payment rate adjustments used to recoup any deficit incurred under the plan.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(4) Using the procedure under s. 227.24, the ~~department~~ board may promulgate rules under sub. (2) or (3) for the period before the effective date of any permanent rules promulgated under sub. (2) or (3), but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the ~~department~~ board is not required to make a finding of emergency.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(5) (a) Annually, no later than April 30, the ~~department~~ board shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, drug manufacturer assessments, and provider payment rate adjustments based on data

and drug distributor

from the previous calendar year. On the basis of the reconciliation, the ~~department~~ board shall make any necessary adjustments in premiums, insurer ~~or manufacturer~~ assessments, or provider payment rates, subject to s. ~~149.142~~ 619.142 (1) (b), for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b).

drug manufacturer or distributor assessments

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

(b) Except as provided in sub. (3) and s. ~~149.144~~ 619.144, the ~~department~~ board shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually, subject to s. ~~149.142~~ 619.142 (1) (b). The ~~department~~ board may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate, subject to s. ~~149.142~~ 619.142 (1) (b).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

SECTION 64. 149.144 of the statutes is renumbered 619.144 and amended to read:

619.144 Adjustments to ~~insurer~~ assessments and ~~provider~~ payment rates for premium and deductible reductions. If the moneys transferred to the fund under the appropriation under s. ~~20.435 (4)~~ 20.145 (5) (ah) are insufficient to reimburse the plan for premium reductions under s. ~~149.165~~ 619.165 and deductible reductions under s. ~~149.14~~ 619.14 (5) (a), or the ~~department~~ board determines that the moneys transferred or to be transferred to the fund under the appropriation under s. ~~20.435 (4)~~ 20.145 (5) (ah) will be insufficient to reimburse the plan for premium reductions under s. ~~149.165~~ 619.165 and deductible reductions under s. ~~149.14~~ 619.14 (5) (a), the ~~department~~ board may, by rule, adjust in equal proportions the ~~amount~~ amounts of the ~~assessment~~ assessments set under s. ~~149.143~~ 619.143 (2) (a) 3. and 3m. and the provider payment rate set under s. ~~149.143~~ 619.143 (2) (a) 4., subject to ss. ~~149.142~~ 619.142 (1) (b) and ~~149.143~~ 619.143 (1) (b) 1., sufficient to

reimburse the plan for premium reductions under s. ~~149.165~~ 619.165 and deductible reductions under s. ~~149.14~~ 619.14 (5) (a). If the ~~department~~ board makes the adjustment under this section, the ~~department~~ board shall notify the commissioner and the pharmacy examining board so that the commissioner may levy any necessary increase in insurer assessments and the pharmacy examining board may levy any necessary increase in drug manufacturer and drug distributor assessments.

History: 1997 a. 27 ss. 4840c, 4845c; 1999 a. 9; 2001 a. 16.

SECTION 65. 149.145 of the statutes is renumbered 619.145 and amended to read:

619.145 Program budget. The ~~department, in consultation with the~~ board, shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. ~~149.142~~ 619.142 and in the most recent provider contracts that are in effect and on the funding sources specified in s. ~~149.143~~ 619.143 (1), including the methodologies specified in ss. ~~149.143, 149.144, and 149.146~~ for determining premium rates, insurer and drug manufacturer and distributor assessments, and provider payment rates. Except as otherwise provided in s. ~~149.143~~ 619.143 (3) (a) and (b) and subject to s. ~~149.142~~ 619.142 (1) (b), from the program budget the ~~department~~ board shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. ~~149.143 and 149.144. The department may not implement a program budget established under this section unless it is approved by the board.~~ plain period

History: 1997 a. 27; 1999 a. 9; 2001 a. 16.

SECTION 66. 149.146 of the statutes is renumbered 619.141, and 619.141 (1) ~~(title)~~ and ~~(2)~~ (2) (a), (am) 4. and 5., and (b) (intro.) and 1., as renumbered, are amended to read:

619.143 and 619.144

619.141, 619.143 and 619.144

and

619.141 **(1)** (a) ~~Beginning on January 1, 1998, in~~ In addition to the coverage required under s. ~~149.14~~ 619.14, the plan shall offer to all eligible persons who are not eligible for ~~medicare~~ Medicare a choice of coverage, as described in section 2744 (a) (1) (C), P.L. 104–191. Any such choice of coverage shall be major medical expense coverage.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

(b) An eligible person under par. (a) may elect once each year, at the time and according to procedures established by the ~~department~~ board, among the coverages offered under this section and s. ~~149.14~~ 619.14. If an eligible person elects new coverage, any preexisting condition exclusion imposed under the new coverage is met to the extent that the eligible person has been previously and continuously covered under this ~~chapter~~ subchapter. No preexisting condition exclusion may be imposed on an eligible person who elects new coverage if the person was an eligible individual when first covered under this ~~chapter~~ subchapter and the person remained continuously covered under this ~~chapter~~ subchapter up to the time of electing the new coverage.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

(2) (a) Except as specified by the ~~department~~ board, the terms of coverage under s. ~~149.14~~ 619.14, including deductible reductions under s. ~~149.14~~ 619.14 (5) (a), do not apply to the coverage offered under this section. Premium reductions under s. ~~149.165~~ 619.165 do not apply to the coverage offered under this section.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

(am) 4. Notwithstanding subds. 1. to 3., the ~~department~~ board may establish different deductible amounts, a different coinsurance percentage, and different covered costs and deductible aggregate amounts from those specified in subds. 1. to

3. in accordance with cost containment provisions established by the ~~department~~ board under s. ~~149.17~~ 619.17 (4).

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

5. ~~Subject to s. 149.14 (8) (b), the department~~ The board may, by rule under s. ~~149.17~~ 619.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which the plan will pay 100% of covered costs for prescription drugs. ~~Any copayment amount, coinsurance rate, or out–of–pocket limit established under this subdivision is subject to the approval of the board.~~ Copayments and coinsurance paid by an eligible person under this subdivision ~~are~~ shall be separate from and ~~do~~ may not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

(b) (intro.) The schedule of premiums for coverage under this section shall be promulgated by rule by the ~~department~~ board, as provided in s. ~~149.143~~ 619.143. The rates for coverage under this section shall be set such that they differ from the rates for coverage under s. ~~149.14~~ 619.14 (2) (a) by the same percentage as the percentage difference between the following:

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

1. The rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. ~~149.14~~ 619.14 (2) (a) and (5) (a) or (d).

SEC. #. RN; 149.15 (title); 619.15 (title)

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

SECTION 67. 149.15 (1) of the statutes is renumbered 619.15 (1) and amended to read:

619.15 **(1)** The plan shall ~~have~~ operate under the direction of a board of governors consisting of representatives of 2 participating insurers that are nonprofit corporations, representatives of 2 other participating insurers, 3 health care

provider representatives, including one representative of the ~~State~~ Wisconsin Medical Society ~~of Wisconsin~~, one representative of the Wisconsin Health and Hospital Association, and one representative of an integrated multidisciplinary health system, and 4 public members, including one representative of small businesses in the state, appointed by the ~~secretary~~ commissioner for staggered 3–year terms. In addition, the commissioner, or a designated representative from the office ~~of the commissioner~~, and the secretary of health and family services, or a designated representative from the department of health and family services, shall be ex officio nonvoting members of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital, or an insurer. At least one of the public members shall be an individual who has coverage under the plan. The ~~secretary or the secretary's representative shall be~~ board annually shall select the chairperson of the board. Board members, except the commissioner or the commissioner's representative and the secretary of health and family services or the ~~secretary's~~ representative of the secretary of health and family services, shall be compensated at the rate of $50 per diem plus actual and necessary expenses.

History: 1979 c. 313; 1981 c. 83; 1987 a. 186, 399; 1991 a. 269; 1997 a. 27 ss. 3027m, 3027r, 4861 to 4878; Stats. 1997 s. 149.15; 1999 a. 9; 2001 a. 16.

SECTION 68. 149.15 (2) of the statutes is renumbered 619.15 (2).

SECTION 69. 149.15 (2m) of the statutes is renumbered 619.15 (2m).

SECTION 70. 149.15 (3) (intro.) of the statutes is renumbered 619.15 (3) (intro.).

SECTION 71. 149.15 (3) (a) of the statutes is renumbered 619.15 (3) (a).

SECTION 72. 149.15 (3) (c) of the statutes is ~~renumbered 619.15 (3) (c) and amended to read:~~ repealed.

619.15 **(3)** (c) Collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred

change component

during the period for which the assessment is made. The level of payments shall be established as provided under s. ~~149.143~~ 619.143. Assessment of the insurers shall occur at the end of each calendar year or other fiscal year-end established by the board. Assessments are due and payable within 30 days of receipt by the insurer of the assessment notice.

History: 1979 c. 313; 1981 c. 83; 1987 a. 186, 399; 1991 a. 269; 1997 a. 27 ss. 3027m, 3027r, 4861 to 4878; Stats. 1997 s. 149.15; 1999 a. 9; 2001 a. 16.

SECTION 73. 149.15 (3) (d) of the statutes is renumbered 619.15 (3) (d).

SECTION 74. 149.15 (3) (f) of the statutes is repealed.

SECTION 75. 149.15 (3) (g) of the statutes is renumbered 619.15 (3) (g) and amended to read:

619.15 **(3)** (g) Establish oversight committees to address various administrative issues, such as financial management of the plan and plan administrator performance standards. A representative of the ~~department~~ office may not be the chairperson of any committee established under this paragraph.

History: 1979 c. 313; 1981 c. 83; 1987 a. 186, 399; 1991 a. 269; 1997 a. 27 ss. 3027m, 3027r, 4861 to 4878; Stats. 1997 s. 149.15; 1999 a. 9; 2001 a. 16.

SECTION 76. 149.15 (4) of the statutes is renumbered 619.15 (4).

SECTION 77. 149.15 (5) of the statutes is repealed.

SECTION 78. 149.15 (6) of the statutes is renumbered 619.15 (5) and amended to read:

619.15 **(5)** If any provision of this ~~chapter~~ subchapter conflicts with s. 625.11 or 625.12, this ~~chapter~~ subchapter prevails.

History: 1979 c. 313; 1981 c. 83; 1987 a. 186, 399; 1991 a. 269; 1997 a. 27 ss. 3027m, 3027r, 4861 to 4878; Stats. 1997 s. 149.15; 1999 a. 9; 2001 a. 16.

SECTION 79. 149.15 (7) of the statutes is renumbered 619.15 (6).

SECTION 80. 149.16 of the statutes is repealed.

SECTION 81. 149.165 of the statutes is renumbered 619.165, and 619.165 (1), (2) (intro.), 1, 2, 3, 4, and 5, and (3) (a) and (b) (intro.), and (4), as renumbered, are amended to read:

619.165 **(1)** Except as provided in s. ~~149.146~~ 619.141 (2) (a), the ~~department~~ board shall reduce the premiums established ~~under s. 149.11~~ in conformity with ss. ~~149.14~~ 619.14 (5m), ~~149.143~~ 619.143, and ~~149.17~~ 619.17 for the eligible persons and in the manner set forth in subs. (2) and (3).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

(2) (a) *[illegible]* Subject to sub. (3m), if the household income, as defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage under s. ~~149.14~~ 619.14 (2) (a) is equal to or greater than the first amount and less than the 2nd amount listed in any of the following, the ~~department~~ board shall reduce the premium for the eligible person to the rate shown after the amounts:

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

1. If equal to or greater than $0 and less than $10,000, to 100% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. ~~149.14~~ 619.14 (2) (a) and (5) (a) or (d).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

2. If equal to or greater than $10,000 and less than $14,000, to 106.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. ~~149.14~~ 619.14 (2) (a) and (5) (a) or (d).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

3. If equal to or greater than $14,000 and less than $17,000, to 115.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. ~~149.14~~ 619.14 (2) (a) and (5) (a) or (d).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

4. If equal to or greater than $17,000 and less than $20,000, to 124.5% of the rate that a standard risk would be charged under an individual policy providing

strike

substantially the same coverage and deductibles as provided under s. ~~149.14~~ 619.14 (2) (a) and (5) (a) or (d).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

5. If equal to or greater than $20,000 and less than $25,000, to 130% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. ~~149.14~~ 619.14 (2) (a) and (5) (a) or (d).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

(bc) Subject to sub. (3m), if the household income, as defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage under s. ~~149.14~~ 619.14 (2) (b) is equal to or greater than the first amount and less than the 2nd amount listed in par. (a) 1., 2., 3., 4., or 5., the ~~department~~ board shall reduce the premium established for the eligible person by the same percentage as the ~~department~~ board reduces, under par. (a), the premium established for an eligible person with coverage under s. ~~149.14~~ 619.14 (2) (a) who has a household income specified in the same subdivision under par. (a) as the household income of the eligible person with coverage under s. ~~149.14~~ 619.14 (2) (b).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

(3) (a) Subject to par. (b), the ~~department~~ board shall establish and implement the method for determining the household income of an eligible person under sub. (2).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

(b) (intro.) In determining household income under sub. (2), the ~~department~~ board shall consider information submitted by an eligible person on a completed federal profit or loss from farming form, schedule F, if all of the following apply:

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

(4) The ~~department~~ commissioner shall reimburse the plan for premium reductions under sub. (2) and deductible reductions under s. ~~149.14~~ 619.14 (5) (a)

with moneys transferred to the fund from the appropriation account under s. ~~20.435 (4)~~ 20.145 (5) (ah).

History: 1985 a. 29; 1987 a. 27; 1987 a. 312 s. 17; 1991 a. 39; 1997 a. 27 ss. 4889 to 4894; Stats. 1997 s. 149.165; 1999 a. 9, 165.

SECTION 82. 149.17 of the statutes is renumbered 619.17, and 619.17 (1), (2) and (4), as renumbered, are amended to read:

619.17 **(1)** Subject to ss. ~~149.14~~ 619.14 (5m), ~~149.143 and 149.146~~ 619.141 (2) (b), and 619.143, a rating plan calculated in accordance with generally accepted actuarial principles.

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39; 1997 a. 27 ss. 4896 to 4900; Stats. 1997 s. 149.17; 1999 a. 9, 165.

(2) A schedule of premiums, deductibles, copayments, and coinsurance payments that complies with all requirements of this ~~chapter~~ subchapter.

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39; 1997 a. 27 ss. 4896 to 4900; Stats. 1997 s. 149.17; 1999 a. 9, 165.

(4) Cost containment provisions established by the ~~department~~ board by rule, including managed care requirements.

History: 1979 c. 313; 1983 a. 27; 1987 a. 27; 1991 a. 39; 1997 a. 27 ss. 4896 to 4900; Stats. 1997 s. 149.17; 1999 a. 9, 165.

SECTION 83. 149.175 of the statutes is renumbered 619.175 and amended to read:

619.175 Waiver or exemption from provisions prohibited. Except as provided in s. ~~149.13~~ 619.13 (1), the ~~department~~ commissioner or the board may not waive~~, or authorize the board to waive,~~ any of the requirements of this ~~chapter~~ subchapter or exempt~~, or authorize the board to exempt,~~ an individual or a class of individuals from any of the requirements of this ~~chapter~~ subchapter.

History: 1991 a. 39; 1997 a. 27 s. 4901; Stats. 1997 s. 149.175.

SECTION 84. 149.18 of the statutes is renumbered 619.18 and amended to read:

619.18 Chapters 600 to 645 applicable. Except as otherwise provided in this ~~chapter~~ subchapter, the plan shall comply and be administered in compliance with chs. 600 to 645.

History: 1979 c. 313; 1981 c. 314; 1997 a. 27 s. 4902; Stats. 1997 s. 149.18.

SECTION 85. 149.20 of the statutes is renumbered 619.20 and amended to read:

619.20 ~~Rule–making in consultation with~~ Rules to be approved by board. ~~In promulgating any~~ Any rules proposed by the commissioner under this ~~chapter, the department shall consult with~~ subchapter may not be promulgated without the approval of the board.

History: 1997 a. 27.

SECTION 86. 149.25 of the statutes is renumbered 619.25, and 619.25 (2) (a) and (c) ~~1., 2.~~, (3) (a) (intro.) and (c), and (4), as renumbered, are amended to read:

619.25 **(2)** (a) The ~~department~~ commissioner and the board shall conduct a 3–year pilot program, beginning on July 1, 2002, under which eligible persons who qualify under par. (b) are provided community–based case management services.

(c) 1. Participation in the pilot program shall be voluntary and limited to no more than 300 eligible persons. The ~~department~~ commissioner or the board shall ensure that all eligible persons are advised in a timely manner of the opportunity to participate in the pilot program and of how to apply for participation.

2. If more than 300 eligible persons apply to participate, the ~~department~~ commissioner or the board shall select pilot program participants from among those who qualify under par. (b) according to standards determined by the ~~department~~ commissioner and the board, except that ~~the department shall give preference to~~ eligible persons who reside in medically underserved areas or health professional shortage areas shall be given preference.

(3) (a) (intro.) The ~~department~~ commissioner and the board shall select and contract with an organization to provide the community–based case management services under the pilot program. To be eligible to provide the services, an organization must satisfy all of the following criteria:

(3)(c) The ~~department~~ commissioner shall pay contract costs from the appropriation under s. ~~20.435 (4)~~ 20.145 (5) (u).

(4) EVALUATION STUDY. The ~~department~~ commissioner, in consultation with the board, shall conduct a study that evaluates the pilot program in terms of health care outcomes and cost avoidance. In the study, the ~~department~~ commissioner shall measure and compare, for pilot program participants and similarly situated eligible persons not participating in the pilot program, plan costs and utilization of services, including inpatient hospital days, rates of hospital readmission within 30 days for the same diagnosis, and prescription drug utilization. The ~~department~~ commissioner shall submit a report on the results of the study, including the ~~department's~~ commissioner's and the board's conclusions and recommendations, to the legislature under s. 13.172 (2) and to the governor.

History: 2001 a. 16.

SECTION 87. 185.981 (4t) of the statutes is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), and (5), 632.895 (10) to (14), and 632.897 (10), subch. II of ch. 619, and ~~chs. 149 and~~ ch. 155.

NOTE: NOTE: Sub. (4t) is shown as affected by two acts of the ~~1999~~ legislature and as merged by the revisor under s. 13.93 (2) (c).NOTE:

History: 1971 c. 40 s. 93; 1971 c. 307 s. 118; 1975 c. 98; 1975 c. 223 s. 28; 1975 c. 224 s. 146; 1975 c. 421; 1981 c. 39 s. 22; 1981 c. 205; 1981 c. 391 s. 210; 1985 a. 29; 1985 a. 30 s. 42; 1987 a. 27 ss. 1917e, 3202 (47) (a); 1987 a. 312 s. 17; 1989 a. 121, 129, 200, 201, 336; 1991 a. 39, 123, 269; 1993 a. 27, 450, 481; 1995 a. 27, 118, 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; s. 13.93 (2) (c).

SECTION 88. 450.10 (1) (b) 4. of the statutes is created to read:

450.10 **(1)** (b) 4. Fails to pay an assessment levied under s. 619.132 within the time required for payment.

SECTION 89. 601.41 (1) of the statutes is amended to read:

601.41 **(1)** DUTIES. The commissioner shall administer and enforce chs. 600 to 655 and ss. 59.52 (11) (c), 66.0137 (4) and (4m), and 120.13 (2) (b) to (g), ~~149.13 and~~

~~149.144~~ and shall act as promptly as possible under the circumstances on all matters placed before the commissioner.

History: 1977 c. 339 s. 43; 1979 c. 89, 102, 177; 1983 a. 358 s. 14; 1985 a. 29; 1985 a. 182 s. 57; 1987 a. 247; 1989 a. 187 s. 29; 1989 a. 201, 336; 1991 a. 39; 1993 a. 16; 1995 a. 201; 1997 a. 27, 51, 252; 1999 a. 150 s. 672; 2001 a. 16, 65, 109.

SECTION 90. 601.415 (12) of the statutes is repealed.

SECTION 91. 601.64 (1) of the statutes is amended to read:

601.64 **(1)** INJUNCTIONS AND RESTRAINING ORDERS. The commissioner may commence an action in circuit court in the name of the state to restrain by temporary or permanent injunction or by temporary restraining order any violation of chs. 600 to 655, ~~s. 149.13 or 149.144,~~ any rule promulgated under chs. 600 to 655, or any order issued under s. 601.41 (4). Except as provided in s. 641.20, the commissioner need not show irreparable harm or lack of an adequate remedy at law in an action commenced under this subsection.

History: 1971 c. 260; Sup. Ct. Order, 67 Wis. 2d 585, 776 (1975); 1975 c. 218, 371, 421; 1977 c. 203; 1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 ss. 78, 236 (5); 1979 c. 177; 1985 a. 29; 1987 a. 167, 247; 1989 a. 332; 1995 a. 396; 1997 a. 27, 283; 2001 a. 109.

SECTION 92. 601.64 (3) (a) of the statutes is amended to read:

601.64 **(3)** (a) *Restitutionary forfeiture.* Whoever violates an effective order issued under s. 601.41 (4)~~,~~ or any insurance statute or rule ~~or s. 149.13 or 149.144~~ shall forfeit to the state twice the amount of any profit gained from the violation, in addition to any other forfeiture or penalty imposed.

History: 1971 c. 260; Sup. Ct. Order, 67 Wis. 2d 585, 776 (1975); 1975 c. 218, 371, 421; 1977 c. 203; 1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 ss. 78, 236 (5); 1979 c. 177; 1985 a. 29; 1987 a. 167, 247; 1989 a. 332; 1995 a. 396; 1997 a. 27, 283; 2001 a. 109.

SECTION 93. 601.64 (3) (c) of the statutes is amended to read:

601.64 **(3)** (c) *Forfeiture for violation of statute or rule.* Whoever violates an insurance statute or rule ~~or s. 149.13 or 149.144~~, intentionally aids a person in violating an insurance statute or rule ~~or s. 149.13 or 149.144~~, or knowingly permits a person over whom he or she has authority to violate an insurance statute or rule ~~or s. 149.13 or 149.144~~ shall forfeit to the state not more than $1,000 for each

violation. If the statute or rule imposes a duty to make a report to the commissioner, each week of delay in complying with the duty is a new violation.

History: 1971 c. 260; Sup. Ct. Order, 67 Wis. 2d 585, 776 (1975); 1975 c. 218, 371, 421; 1977 c. 203; 1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 ss. 78, 236 (5); 1979 c. 177; 1985 a. 29; 1987 a. 167, 247; 1989 a. 332; 1995 a. 396; 1997 a. 27, 283; 2001 a. 109.

SECTION 94. 601.64 (4) of the statutes is amended to read:

601.64 **(4)** CRIMINAL PENALTY. Whoever intentionally violates or intentionally permits any person over whom he or she has authority to violate or intentionally aids any person in violating any insurance statute or rule of this state~~, s. 149.13 or 149.144~~ or any effective order issued under s. 601.41 (4) is guilty of a Class I felony, unless a specific penalty is provided elsewhere in the statutes. Intent has the meaning expressed under s. 939.23.

History: 1971 c. 260; Sup. Ct. Order, 67 Wis. 2d 585, 776 (1975); 1975 c. 218, 371, 421; 1977 c. 203; 1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 ss. 78, 236 (5); 1979 c. 177; 1985 a. 29; 1987 a. 167, 247; 1989 a. 332; 1995 a. 396; 1997 a. 27, 283; 2001 a. 109.

SECTION 95. 613.03 (3) of the statutes is amended to read:

613.03 **(3)** APPLICABILITY OF INSURANCE LAWS. Except as otherwise specifically provided, service insurance corporations organized or operating under this chapter are subject to ss. 610.01, 610.11, 610.21, 610.23, and 610.24, subch. II of ch. 619, and chs. 600, 601, 609, 617, 620, 623, 625, 627, 628, 631, 632, 635, 644, and 645 and to no other insurance laws.

History: 1975 c. 223; 1979 c. 102 ss. 125, 126; 1979 c. 313; 1981 c. 38 s. 26; 1983 a. 215 s. 17; 1989 a. 23; 1991 a. 250; 1997 a. 27, 227.

SECTION 96. 613.04 of the statutes is repealed.

SECTION 97. 614.05 (1) of the statutes is amended to read:

614.05 **(1)** CHAPTERS 611 AND 619. No section of ch. 611 or of subch. I of ch. 619 applies to fraternals unless it is specifically made applicable by this chapter.

History: 1975 c. 373; 1979 c. 89; 1995 a. 27; 1997 a. 27.

SECTION 98. Subchapter I (title) of chapter 619 [precedes 619.01] of the statutes is created to read:

SUBCHAPTER I
GENERAL PROVISIONS

SECTION 99. Subchapter II of chapter 619 [precedes 619.10] of the statutes is created to read:

(title) SUBCHAPTER II
MANDATORY HEALTH INSURANCE
RISK-SHARING PLAN
Hard Return

RP, 613.03(4)

CHAPTER 619

SECTION 100. 619.10 (2p) of the statutes is created to read:

619.10 **(2p)** "Drug distributor" means a person licensed by the pharmacy examining board under s. 450.07 (2).

SECTION 101. 619.10 (2r) of the statutes is created to read:

619.10 **(2r)** "Drug manufacturer" means a person licensed by the pharmacy examining board under s. 450.07 (1).

SECTION 102. 619.13 (2) of the statutes is created to read:

619.13 **(2)** Each insurer's share of the operating, administrative, and subsidy expenses of the plan shall be determined by the commissioner in the following manner:

(a) First, the commissioner shall divide all insurers into 2 groups, depending on whether an insurer is a stop-loss carrier.

(b) Next, the commissioner shall determine the number of residents covered during the preceding calendar year by the group of insurers that are not stop-loss carriers and the number of residents covered during the preceding calendar year by the group of insurers that are stop-loss carriers. The commissioner shall then apportion to each group of insurers the proportion of the total assessments estimated by the board under s. 619.143 (2) (a) 3. that the number of residents covered by the group bears to the total number of residents covered by both groups combined.

(c) Next, the commissioner shall determine ~~each insurer's~~ the health care coverage revenue for residents during the preceding calendar year and ~~each group's~~ the aggregate health care coverage revenue for residents during the preceding calendar year. Except as provided in sub. (1), each insurer shall share in the total estimated assessments apportioned to the insurer's group under par. (b) in the proportion that the insurer's total health care coverage revenue for residents during the preceding

of each insurer

of each insurer group determined under par. (a)

calendar year bears to the aggregate health care coverage revenue of all insurers in the insurer's group for residents during the preceding calendar year, as determined by the commissioner.

SECTION 103. 619.132 of the statutes is created to read:

619.132 Participation of drug manufacturers and distributors. Every drug manufacturer and drug distributor shall participate in the cost of administering the plan in the manner provided in ss. 619.143 and 619.144. The board shall determine the methodology for assessing drug manufacturers and drug distributors. The commissioner shall advise the pharmacy examining board of the assessment amounts that must be levied. The pharmacy examining board shall levy and collect the assessments and ~~[illegible]~~ forward the amounts collected to the commissioner for deposit in the Health Insurance Risk–Sharing Plan fund.

SECTION 104. 619.143 (1) (b) 2. am. of the statutes is created to read:

619.143 **(1)** (b) 2. am. One–third from drug manufacturer and drug distributor assessments, excluding assessments under s. 619.144.

SECTION 105. 619.143 (2) (a) 3m. of the statutes is created to read:

619.143 **(2)** (a) 3m. By the same rule as under subd. 3., set the total drug manufacturer and drug distributor assessments under s. 619.132 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. am. and notify the pharmacy examining board of the amount.

SECTION 106. 619.15 (3) (b) of the statutes is created to read:

619.15 **(3)** (b) Establish, by rule, the plan design, including covered benefits and copayment and deductible amounts. At least every 3 years, the board shall conduct a survey of health care plans available in the private market and make any

adjustments to the plan that the board determines is advisable on the basis of the survey. Using the procedure under s. 227.24, the board may promulgate rules under this paragraph for the period before the effective date of any permanent rules promulgated under this paragraph, but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the board is not required to make a finding of emergency.

SECTION 107. 619.15 (3) (e) of the statutes is created to read:

619.15 **(3)** (e) Select a plan administrator in a competitive, request–for–proposals process and enter into a contract with the person selected.

SECTION 108. 619.15 (3) (em) of the statutes is created to read:

619.15 **(3)** (em) Contract with persons to provide professional services to the board and the plan.

SECTION 109. 619.15 (4) (c) of the statutes is created to read:

619.15 **(4)** (c) Notwithstanding ss. 625.11 (4) and 628.34 (3) (a) and any requirements in this subchapter related to setting premium rates or amounts, establish [illegible] for eligible persons with household incomes that exceed $100,000. Premium rates established under this paragraph may not exceed 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles that are provided under the plan. Notwithstanding s. 619.143 (2m) (b), the board may use excess premiums collected under a schedule established under this paragraph to reduce premiums for eligible persons with low household incomes, as determined by the board.

SECTION 110. 631.36 (7) (a) 2. of the statutes is amended to read:

631.36 **(7)** (a) 2. Unless the notice contains adequate instructions to the policyholder for applying for insurance through a risk–sharing plan under subch. I of ch. 619, if a risk–sharing plan exists under subch. I of ch. 619 for the kind of coverage being canceled or nonrenewed, except as provided in par. (b).

History: 1975 c. 375, 421; 1977 c. 444 s. 11; 1979 c. 102; 1979 c. 110 s. 60 (11); 1981 c. 83; 1985 a. 335; 1989 a. 187, 332, 359; 1991 a. 315; 1995 a. 259; 1997 a. 27; 1999 a. 9.

SECTION 111. 632.785 (1) (intro.) of the statutes is amended to read:

632.785 **(1)** (intro.) If an insurer issues one or more of the following or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible under s. ~~149.12~~ 619.12 for coverage under ~~ch. 149~~ subch. II of ch. 619, the insurer shall notify all persons affected of the existence of the mandatory ~~health insurance risk–sharing plan~~ Health Insurance Risk–Sharing Plan under ~~ch. 149~~ subch. II of ch. 619, as well as the eligibility requirements and method of applying for coverage under the plan:

History: 1979 c. 313; 1981 c. 83; 1991 a. 315; 1997 a. 27.

SECTION 9124. Nonstatutory provisions; health and family services.

(1) TRANSFER OF HEALTH INSURANCE RISK–SHARING PLAN TO OFFICE OF COMMISSIONER OF INSURANCE.

(a) *Assets and liabilities.* On the effective date of this paragraph, all assets and liabilities of the department of health and family services primarily related to the mandatory Health Insurance Risk–Sharing Plan, as determined by the secretary of administration, shall become the assets and liabilities of the office of the commissioner of insurance.

(b) *Tangible personal property.* On the effective date of this paragraph, all tangible personal property, including records, of the department of health and family services primarily related to the mandatory Health Insurance Risk–Sharing Plan,

as determined by the secretary of administration, is transferred to the office of the commissioner of insurance.

(c) *Contracts.* All contracts entered into by the department of health and family services that are in effect on the effective date of this paragraph and that are primarily related to the mandatory Health Insurance Risk–Sharing Plan, as determined by the secretary of administration, remain in effect and are transferred to the office of the commissioner of insurance. The office of the commissioner of insurance shall carry out any obligations under such a contract until the contract is modified or rescinded by the office of the commissioner of insurance to the extent allowed under the contract.

(d) *Pending matters.* Any matter pending with the department of health and family services on the effective date of this paragraph that is primarily related to the mandatory Health Insurance Risk–Sharing Plan is transferred to the office of the commissioner of insurance, and all materials submitted to or actions taken by the department of health and family services with respect to the pending matter are considered as having been submitted to or taken by the office of the commissioner of insurance.

(e) *Rules and orders.* All rules promulgated by the department of health and family services that are in effect on the effective date of this paragraph and that are primarily related to the mandatory Health Insurance Risk–Sharing Plan remain in effect until their specified expiration date or until amended or repealed by the office of the commissioner of insurance. All orders issued by the department of health and family services that are in effect on the effective date of this paragraph and that are primarily related to the mandatory Health Insurance Risk–Sharing Plan remain in

effect until their specified expiration date or until modified or rescinded by the office of the commissioner of insurance.

SECTION 9128. Nonstatutory provisions; insurance.

(1) GENERAL FUND APPROPRIATIONS. Notwithstanding section 16.42 (1) (e) of the statutes, in submitting information under section 16.42 of the statutes for purposes of the 2005–07 biennial budget bill, the office of the commissioner of insurance shall submit information concerning the appropriation under section 20.145 (5) (af) of the statutes as though the amount appropriated to the office under that appropriation for fiscal year 2004–05 were $9,500,000 more than the amount in the schedule and shall submit information concerning the appropriation under section 20.145 (5) (ah) of the statutes as though the amount appropriated to the office under that appropriation for fiscal year 2004–05 were $741,800 more than the amount in the schedule.

(2) SELECTION OF PLAN ADMINISTRATOR. The board of governors of the Health Insurance Risk–Sharing Plan shall, no later than December 1, 2003, issue a request–for–proposals under section 619.15 (3) (e) of the statutes, as created by this act, for administration of the Health Insurance Risk–Sharing Plan.

(END)

as affected by this act)

Insert 36-17

D-note

INSERT 8–10

619.14 **(1)** (b) If an individual terminates ~~medical assistance~~ Medical Assistance coverage and applies for coverage under the plan within 45 days after the termination and is subsequently found to be eligible under s. ~~149.12~~ 619.12, the effective date of coverage for the eligible person under the plan shall be the date of termination of ~~medical assistance~~ Medical Assistance coverage.

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16.

(END OF INSERT 8–10)

INSERT 12–18

(2) Except as provided in sub. (1) (b), the rates established under this section are subject to adjustment under ss. ~~149.143 and 149.144~~ 619.143 and 619.144.

(END OF INSERT 12–18)

INSERT 28–20

SECTION 1. 450.10 (2m) of the statutes is created to read:

450.10 **(2m)** If a manufacturer or distributor fails to pay an assessment levied under s. 619.132 within the time required for payment, the board may assess a forfeiture of not more than $1,000 for each day that the payment is past due.

(END OF INSERT 28–20)

INSERT 33–17

not a separate schedule of premium rates that are higher than the rates set for other eligible persons

(END OF INSERT 33–17)

INSERT 36–17

ins 36-17

SECTION 9328. Initial applicability; insurance.

(1) HEALTH INSURANCE RISK–SHARING PLAN. With respect to changes in plan design, including covered expenses and exclusions, deductibles, copayments, coinsurance, and out–of–pocket limits, the treatment of sections of the statutes first applies to the plan year beginning on January 1, 2004.

insert 36-17A

SECTION 9428. Effective dates; insurance.

(1) HEALTH INSURANCE RISK–SHARING PLAN. The treatment of sections take effect on the first day 3rd month beginning after publication.

(END OF INSERT 36–17)

of the

insert 36-17B

This act takes effect on the day after publication, except as follows:

Insert 36-17A

149.14 (3) (intro.) and (a) to (r), (4), and (5), 149.146, 149.17, and 619.15 (3) (b)

(end of ins 36-17A)

Insert 36-17 B

20.145 (5) (title), 20.435 (4) (af), (ah), (4), and (v), 25.55 (1), (2), (3), and (4), 71.65 (4), 149.10 (intro), (2), (2c), (2f), (2j), (2m), (2t), (3), (3c), (3d), (3e), (3g), (3j), (3m), (4), (4c), (4m), (4p), (5), (5m), (6), (7), (8), (8b), (8c), (8j), (8m), (8p), (9), (10), and (11), 149.11, 149.115, 149.12, 149.13 (1), (2), (3), and (4), 149.14 (title), (1), (2), (3) (intro.) and (a) to (r), (4), (4c), (4m), (5), (5m), (6), (7), and (8), 149.142, 149.143, 149.144, 149.145, 149.146, 149.15 (1), (2), (2m), (3) (intro.), (a), (c), (d), (f), and (g), (4), (5), (6), and (7), 149.16, 149.165, 149.17, 149.175, 149.18, 149.20, 149.25, 185.981 (4t), 450.10 (2m), 601.41 (1), 601.415 (12), 601.64 (1), (3) (a) and (c), and (4), 613.03 (3) and (4), 614.05 (1), 619.10 (2p) and (2r), 619.13 (2), 619.132, 619.143 (2) (a) 3m., 619.15 (3) (b), (e), and (em) and (4) (c), 631.36 (7) (a) 2. and 632.785 (1) (intro.) subchapter I (title) ~~of chapter 619~~ and subchapter II of chapter 619 of the statutes and SECTION 9124 (1) of this act

(and of ins 36-17 B)

(1) (b) 2. am. and

, chapter 149 (title), and

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2476/1dn P1
PJK:...

1. Although the intention is for this draft to be a budget amendment, I drafted it for now as a bill without an analysis because it is a little quicker for me and perhaps a little easier for you to see the changes. When you are reviewing the language, especially note the newly created provisions in ch. 619.

2. Notice the nonstatutory provision for the general fund appropriations. This is our standard provision related to lapsing amounts in the schedule for the purpose of establishing "base" amounts.

3. I can convert this draft to a budget amendment, if you wish, after any necessary changes are finalized.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: pam.kahler@legis.state.wi.us

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2476/P1dn
PJK:kmg:ch

April 21, 2003

1. Although the intention is for this draft to be a budget amendment, I drafted it for now as a bill without an analysis because it is a little quicker for me and perhaps a little easier for you to see the changes. When you are reviewing the language, especially note the newly created provisions in ch. 619.

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Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: pam.kahler@legis.state.wi.us

CREATE

s. 149.132 Participation of pharmaceutical manufacturers. (1)) Every pharmaceutical manufacturer doing business in Wisconsin shall, for the privilege of doing business in Wisconsin, participate in the cost of administering the plan, except the board may by rule exempt as a class those pharmaceutical manufacturers whose share as determined under sub. (2) would be so minimal as to not exceed the estimated cost of levying the assessment.

(2) Every pharmaceutical manufacturer doing business in Wisconsin shall, for the privilege of doing business in Wisconsin, share in the operating, administrative and subsidy expenses of the plan in proportion to the ratio of the pharmaceutical manufacturer's gross receipts or gross revenues of prescription medicines provided to Wisconsin residents eligible for medical assistance under subch. IV of ch. 49 during the preceding calendar year, as determined by the department.

(3) (a) Each pharmaceutical manufacturer's proportion of participation under sub. (2) shall be determined annually by the board based on annual statements and other reports or information filed with the department. The board shall assess a pharmaceutical manufacturer for the pharmaceutical manufacturer's proportion of participation based on the total assessments estimated by the board under s. 149.143 (2) (a) 5.

(b) If the board finds that the board's authority to require pharmaceutical manufacturers to report or provide requested information is not adequate to permit the board to carry out the board's responsibilities under this chapter, the board shall promulgate rules requiring pharmaceutical manufacturers to report the information necessary for the board to make the determinations required under this chapter.

AMEND

ss. 149.143, 149.144, 149.145

149.143 Payment of plan costs. (1) The department shall pay or recover the operating costs of the plan from the appropriation under s. 20.435 (4) (v) and administrative costs of the plan from the appropriation under s. 20.435 (4) (u). For purposes of determining premiums, insurer assessments, ~~and~~ provider payment rate adjustments, and pharmaceutical manufacturer assessments, the department shall apportion and prioritize responsibility for payment or recovery of plan costs from among the moneys constituting the fund as follows:

(a) First from the moneys transferred to the fund from the appropriation account under s. 20.435 (4) (af).

(b) The remainder of the costs as follows:

1. A total of 60% from the following sources, calculated as follows:

a. First, from premiums from eligible persons with coverage under s. 149.14 (2) (a) set at a rate that is 140% to 150% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) set in accordance with s. 149.14 (5m), including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435 (4) (ah), and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b).

b. Second, from moneys specified under sub. (2m), to the extent that the amounts under subd. 1. a. are insufficient to pay 60% of plan costs.

c. Third, by increasing premiums from eligible persons with coverage under s. 149.14 (2) (a) to more than the rate at which premiums were set under subd. 1. a. but not more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) by a comparable amount in accordance with s. 149.14 (5m), including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435 (4) (ah), and by increasing premiums from eligible persons with coverage under s. 149.146 in accordance with s. 149.146 (2) (b), to the extent that the amounts under subd. 1. a. and b. are insufficient to pay 60% of plan costs.

d. Fourth, notwithstanding subd. 2., by increasing insurer assessments, excluding assessments under s. 149.144, ~~and~~ adjusting provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144, and increasing pharmaceutical manufacturer assessments, excluding assessments under s. 149.144, in equal proportions

and to the extent that the amounts under subd. 1. a. to c. are insufficient to pay 60% of plan costs.

2. A total of 40% as follows:

a. ~~Fifty percent~~ One-third from insurer assessments, excluding assessments under s. 149.144.

b. ~~Fifty percent~~ One-third from adjustments to provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144.

c. One-third from pharmaceutical manufacturer assessments, excluding assessments under s. 149.144.

(2) (a) Prior to each plan year, the department shall estimate the operating and administrative costs of the plan and the costs of the premium reductions under s. 149.165 and the deductible reductions under s. 149.14 (5) (a) for the new plan year and do all of the following:

1. a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set at a level sufficient, when including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435 (4) (ah) and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b), to cover 60% of the estimated plan costs for the new plan year, after deducting from the estimated plan costs the amount available for transfer to the fund from the appropriation account under s. 20.435 (4) (af) for that plan year.

b. Estimate the amount of enrollee premiums that will be received under sub. (1) (b) 1. a.

2. After making the determinations under subd. 1., by rule set premium rates for the new plan year, including the rates under s. 149.146 (2) (b), in the manner specified in sub. (1) (b) 1. a. and c. and such that a rate for coverage under s. 149.14 (2) (a) is approved by the board and is not less than 140% nor more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

3. By rule set the total insurer assessments under s. 149.13 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. a. and notify the commissioner of the amount.

4. By the same rule as under subd. 3. adjust the provider payment rate for the new plan year, subject to s. 149.142 (1) (b), by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. b. and as provided in s. 149.145.

5. By the same rule as under subd. 3 adjust the pharmaceutical manufacturer assessment for the new plan year subject to s. 149.142 (1) (b), by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. c. and as provided in s. 149.145.

(b) In setting the premium rates under par. (a) 2., the insurer assessment amount under par. (a) 3. and the provider payment rate under par. (a) 4. for the new plan year, the department shall include any increase or decrease necessary to reflect the amount, if any,
by which the rates and amount set under par. (a) for the current plan year differed from the rates and amount which would have equaled the amounts specified in sub. (1) (b) in the current plan year.

(2m) (a) The department shall keep a separate accounting of the difference between the following:

1. The amount of premiums received in a plan year from all eligible persons, including amounts received for premium and deductible subsidies.

2. The amount of premiums, including amounts received for premium and deductible subsidies, necessary to cover 60% of the plan costs for the plan year, after deducting the amount transferred to the fund from the appropriation account under s. 20.435 (4) (af).

(b) Any amount by which the amount under par. (a) 1. exceeds the amount under par. (a) 2. may be used only as follows:

1. To reduce premiums in succeeding plan years as provided in sub. (1) (b) 1. b. For eligible persons with coverage under s. 149.14 (2) (a), premiums may not be reduced below 140% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

2. For other needs of eligible persons, with the approval of the board.

3. For distribution to eligible persons, notwithstanding any requirements in this chapter related to setting premium amounts. The department, with the approval of the board and the concurrence of the plan actuary, shall determine the policies, eligibility criteria, methodology, and other factors to be used in making any distribution under this subdivision.

(3) (a) If, during a plan year, the department determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer assessments, ~~and~~ the provider payment rate, and the pharmaceutical manufacturer assessment under s. 149.144 will not be sufficient to cover plan costs, the department may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3.

for the remainder of the plan year, subject to sub. (1) (b) 2. a., ~~and~~ by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4., subject to sub. (1) (b) 2. b. and s. 149.142 (1) (b), and by the same rule under which assessments are increased adjust the pharmaceutical manufacturer assessment set under sub. (2) (a) 5. for the remainder of the plan year, subject to sub. (1) (b) 2. c.

(b) If the department increases premium rates and insurer assessments, ~~and~~ adjusts the provider payment rate, and increases pharmaceutical manufacturer assessments under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the department may further adjust, in equal proportions, assessments set under sub. (2) (a) 3., ~~and~~ the provider payment rate set under sub. (2) (a) 4., and pharmaceutical manufacturer assessments without regard to sub. (1) (b) 2. but subject to s. 149.142 (1) (b).

(3m) Subject to s. 149.14 (4m), insurers, ~~and~~ providers, and pharmaceutical manufacturers may recover in the normal course of their respective businesses without time limitation assessments or provider payment rate adjustments used to recoup any deficit incurred under the plan.

(4) Using the procedure under s. 227.24, the department may promulgate rules under sub. (2) or (3) for the period before the effective date of any permanent rules promulgated under sub. (2) or (3), but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the department is not required to make a finding of emergency.

(5) (a) Annually, no later than April 30, the department shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, ~~and~~ provider payment rate adjustments, and pharmaceutical manufacturer assessments based on data from the previous calendar year. On the basis of the reconciliation, the department shall make any necessary adjustments in premiums, insurer assessments, or provider payment rates, or pharmaceutical manufacturer assessments subject to s. 149.142 (1) (b), for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b).

(b) Except as provided in sub. (3) and s. 149.144, the department shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually, subject to s. 149.142 (1) (b). The department may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate, subject to s. 149.142 (1) (b).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109.

Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.144 Adjustments to insurer assessments, ~~and~~ provider payment rates, and pharmaceutical manufacturer assessments for premium and deductible reductions. If the moneys transferred to the fund under the appropriation under s. 20.435 (4) (ah) are insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), or the department determines that the moneys transferred or to be transferred to the fund under the appropriation under s. 20.435 (4) (ah) will be insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), the department may, by rule, adjust in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3., ~~and~~ the provider payment rate set under s. 149.143 (2) (a) 4., and the pharmaceutical manufacturer assessment under s. 149.143 (2) (a) 5., subject to ss. 149.142 (1) (b) and 149.143 (1) (b) 1., sufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a). If the department makes the adjustment under this section, the department shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

History: 1997 a. 27 ss. 4840c, 4845c; 1999 a. 9; 2001 a. 16.

Cross Reference: See also ch. HFS 119, Wis. adm. code.

149.145 Program budget. The department, in consultation with the board, shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in s. 149.143 (1), including the methodologies specified in ss. 149.143, 149.144, and 149.146 for determining premium rates, insurer assessments, ~~and~~ provider payment rates, and pharmaceutical manufacturer assessments. Except as otherwise provided in s. 149.143 (3) (a) and (b) and subject to s. 149.142 (1) (b), from the program budget the department shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The department may not implement a program budget established under this section unless it is approved by the board.

History: 1997 a. 27; 1999 a. 9; 2001 a. 16.

LaBudde, Susan

From: Zambito, Gina
Sent: Tuesday, April 22, 2003 10:35 AM
To: LaBudde, Susan
Subject: FW: HIRSP revision and gross receipts tax on pharmaceutical companies

Importance: High

Let me know if this is not what you are looking for.

-----Original Message-----
From: LaBudde, Susan
Sent: Thursday, April 10, 2003 5:23 PM
To: 'Sandy Lonergan'; 'bbroydrick@broydrick.com'
Subject: HIRSP revision and gross receipts tax on pharmaceutical companies
Importance: High

Bill:

Attached is a very preliminary redlined revised text of section 149.143 relating to the re-allocation of HIRSP costs (from 40/60% under (1)(b)1 and 2, to 1/3rd each, including on pharmaceutical companies).

For tax purposes, the key language is very simple: we need to (1) refer to the assessment as on gross receipts or gross revenues (2) for the privilege of doing business in Wisconsin, and (3) limit the base of revenues to those revenues derived from business done/ sales made in Wisconsin.

I have done that by adding a new subsection 3. to 149.143(1)(b). However, I have absolutely no familiarity with HIRSP and all of the intricacies of cost sharing and participation calculations under chapter 149 and the administrative code.

For example, I note that section 149.13 sets forth the required participation of insurers who meet certain thresholds. I assume that your HIRSP lawyer consultants will be drafting a new similar free-standing section applicable to pharmaceutical companies. In such case, I could see moving some of the "for th privilege of..." language in my new section to such new free-standing section.

However, I leave that to your HIRSP experts to draft the pharmaceutical provisions consistent with the rest of chapter 149.

From a tax perspective, I believe that the Wisconsin DOR **WILL** have sufficient nexus over pharmaceutical companies that have sales reps doing business in the State. As we discussed yesterday, the solicitation safe harbor of Public Law 86-272 applies only to imposition of an income tax and not to a gross receipts tax. The Supreme Court has held that a taxpayer has sufficient nexus with a state if its regular sales reps in that state.

Please let me know how I can be of further assistance. I would be more than happy work with the lawyers you have lined up on the HIRSp reform end of things.

Have you been working at all with Pat Osborne, who is WALHI's lobbyist and is also working on this?

section 149.143 REVISED.doc

Susan A. LaBudde
Legal Department
Cobalt Corporation
401 W. Michigan St
Milwaukee, WI 53203
Phone: (414) 226-6061
Fax: (414) 226-6229
susan.labudde@cobalt-corp.com

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149.143. Payment of plan costs

(1) The department shall pay or recover the operating costs of the plan from the appropriation under s. 20.435(4)(v) and administrative costs of the plan from the appropriation under s. 20.435(4)(u). For purposes of determining premiums, insurer assessments and provider payment rate adjustments, the department shall apportion and prioritize responsibility for payment or recovery of plan costs from among the moneys constituting the fund as follows:

(a) First from the moneys transferred to the fund from the appropriation account under s. 20.435(4)(af).

(b) The remainder of the costs as follows:

1. A total of ~~60%~~one-third from the following sources, calculated as follows:

a. First, from premiums from eligible persons with coverage under s. 149.14(2)(a) set at a rate that is 140% to 150% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. 149.14(2)(b) set in accordance with s. 149.14(5m), including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435(4)(ah), and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146(2)(b).

b. Second, from moneys specified under sub. (2m), to the extent that the amounts under subd. 1.a. are insufficient to pay one-third ~~60%~~ of plan costs.

c. Third, by increasing premiums from eligible persons with coverage under s. 149.14(2)(a) to more than the rate at which premiums were set under subd. 1. a. but not more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan and from eligible persons with coverage under s. 149.14(2)(b) by a comparable amount in accordance with s. 149.14(5m), including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435(4)(ah), and by increasing premiums from eligible persons with coverage under s. 149.146 in accordance with s. 149.146(2)(b), to the extent that the amounts under subd. 1. a. and b. are insufficient to pay one-third ~~60%~~ of plan costs.

d. Fourth, notwithstanding subd. 2., by increasing insurer assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, subject to s. 149.142(1)(b) and excluding adjustments to those rates under s. 149.144, in equal proportions and to the extent that the amounts under subd. 1. a. to c. are insufficient to pay one-third ~~60%~~ of plan costs.

2. A total of one-third ~~40%~~ as follows:

a. Fifty percent from insurer assessments, excluding assessments under s. 149.144.

b. Fifty percent from adjustments to provider payment rates, subject to s. 149.142(1)(b) and excluding adjustments to those rates under s. 149.144.

3. A total of one-third as follows:

a. From a 1% fee assessed for the privilege of doing business in Wisconsin on those gross revenues of pharmaceutical manufacturers derived from the sale of prescription

medicines for use by Wisconsin residents.

(2)(a) Prior to each plan year, the department shall estimate the operating and administrative costs of the plan and the costs of the premium reductions under s. 149.165 and the deductible reductions under s. 149.14(5)(a) for the new plan year and do all of the following:

1. a. Estimate the amount of enrollee premiums that would be received in the new plan year if the enrollee premiums were set at a level sufficient, when including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435(4)(ah) and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146(2)(b), to cover one-third ~~60%~~ of the estimated plan costs for the new plan year, after deducting from the estimated plan costs the amount available for transfer to the fund from the appropriation account under s. 20.435(4)(af) for that plan year.

b. Estimate the amount of enrollee premiums that will be received under sub. (1)(b)1.a.

2. After making the determinations under subd. 1., by rule set premium rates for the new plan year, including the rates under s. 149.146(2)(b), in the manner specified in sub. (1)(b)1. a. and c. and such that a rate for coverage under s. 149.14(2)(a) is approved by the board and is not less than 140% nor more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

3. By rule set the total insurer assessments under s. 149.13 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1)(b)1.d. and 2.a. and notify the commissioner of the amount.

4. By the same rule as under subd. 3. adjust the provider payment rate for the new plan year, subject to s. 149.142(1)(b), by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1)(b)1. d. and 2. b. and as provided in s. 149.145.

(b) In setting the premium rates under par. (a)2., the insurer assessment amount under par. (a)3. and the provider payment rate under par. (a)4. for the new plan year, the department shall include any increase or decrease necessary to reflect the amount, if any, by which the rates and amount set under par. (a) for the current plan year differed from the rates and amount which would have equaled the amounts specified in sub. (1)(b) in the current plan year.

(2m)(a) The department shall keep a separate accounting of the difference between the following:

1. The amount of premiums received in a plan year from all eligible persons, including amounts received for premium and deductible subsidies.

2. The amount of premiums, including amounts received for premium and deductible subsidies, necessary to cover one-third ~~60%~~ of the plan costs for the plan year, after deducting the amount transferred to the fund from the appropriation account under s. 20.435(4)(af).

(b) Any amount by which the amount under par. (a)1. exceeds the amount under par. (a)2. may be used only as follows:

1. To reduce premiums in succeeding plan years as provided in sub. (1)(b)1. b. For eligible persons with coverage under s. 149.14(2)(a), premiums may not be reduced below 140% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as are provided under the plan.

2. For other needs of eligible persons, with the approval of the board.
3. For distribution to eligible persons, notwithstanding any requirements in this chapter related to setting premium amounts. The department, with the approval of the board and the concurrence of the plan actuary, shall determine the policies, eligibility criteria, methodology, and other factors to be used in making any distribution under this subdivision.
(3)(a) If, during a plan year, the department determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2)(a)2. to 4. and any adjustments in insurer assessments and the provider payment rate under s. 149.144 will not be sufficient to cover plan costs, the department may by rule increase the premium rates set under sub. (2)(a)2. for the remainder of the plan year, subject to s. 149.146(2)(b) and the maximum specified in sub. (2)(a)2., by rule increase the assessments set under sub. (2)(a)3. for the remainder of the plan year, subject to sub. (1)(b) 2. a., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2)(a)4. for the remainder of the plan year, subject to sub. (1)(b)2. b. and s. 149.142(1)(b).
(b) If the department increases premium rates and insurer assessments and adjusts the provider payment rate under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the department may further adjust, in equal proportions, assessments set under sub. (2)(a)3. and the provider payment rate set under sub. (2)(a)4., without regard to sub. (1)(b)2. but subject to s. 149.142(1)(b).
(3m) Subject to s. 149.14(4m), insurers and providers may recover in the normal course of their respective businesses without time limitation assessments or provider payment rate adjustments used to recoup any deficit incurred under the plan.
(4) Using the procedure under s. 227.24, the department may promulgate rules under sub. (2) or (3) for the period before the effective date of any permanent rules promulgated under sub. (2) or (3), but not to exceed the period authorized under s. 227.24(1)(c) and (2). Notwithstanding s. 227.24(1) and (3), the department is not required to make a finding of emergency.
(5)(a) Annually, no later than April 30, the department shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, and provider payment rate adjustments based on data from the previous calendar year. On the basis of the reconciliation, the department shall make any necessary adjustments in premiums, insurer assessments or provider payment rates, subject to s. 149.142(1)(b), for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2)(b).
(b) Except as provided in sub. (3) and s. 149.144, the department shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually, subject to s. 149.142(1)(b). The department may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate, subject to s. 149.142(1)(b).

Wisconsin Association of Health Plans

10 East Doty Street
Suite 503
Madison, Wisconsin 53703
Tel.: (608) 255-8599
Fax: (608) 255-8627

FAX TRANSMISSION COVER SHEET

DATE:	April 22, 2003
RECIPIENT:	Sandy L.
FACSIMILE:	255-4612
SENDER(S):	Joe Kachelski
REGARDING:	

_____ **For Your Information**
_____ **Per Your Request**
Response Needed: ___ **YES** ___ **NO**

MESSAGE:

Stop/Loss

YOU SHOULD RECEIVE 9 **PAGES, INCLUDING THIS COVER SHEET.**
IF YOU DO NOT RECEIVE ALL THE PAGES PLEASE CALL (608) 255-8599.

New Regulation 4-2-22

Insurer Assessments for CoverColorado

Section 1 Authority
Section 2 Background and Purpose
Section 3 Definitions
Section 4 Determination of Need for Special Fee Assessment
Section 5 Determination of Amount of Assessment to Each Insurer
Section 6 Notice and Collection of the Assessed Special Fees
Section 7 Deferral of or Credit Against Special Fees
Section 8 Severability
Section 9 Effective Date
Section 10 History

Section 1 Authority

This regulation is promulgated under the authority of Sections 10-1-109 and 10-8-530(1.5), C.R.S.

Section 2 Background and Purpose

CoverColorado, formerly the Colorado Uninsurable Health Insurance Plan, was created by legislation in 1990 to provide access to health insurance for those Colorado residents who are termed "high risk" because they are unable to obtain health insurance or unable to obtain health insurance except at prohibitive rates or with restrictive exclusions. CoverColorado enrollment has increased and will continue to increase as CoverColorado becomes the state alternative mechanism for federally eligible individuals, as defined in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to keep up with the rising medical care costs for eligible individuals, §10-8-530(1.5), C.R.S. was enacted to permit CoverColorado to assess special fees against certain insurers in Colorado, as necessary, to pay projected administrative expenses and losses of the program. Such special fees will be used to supplement premiums and other sources of funding, as set forth in §10-8-530(1), C.R.S., received by the program.

The purpose of this regulation is to establish the procedures for the assessment of special fees for the CoverColorado program.

Section 3 Definitions

For the purposes of this regulation, the following terms shall have the meanings set forth below:

A. "Benefit design weighted average" means the average actuarial value of the benefits provided under all plans issued in Colorado by the insurer during the previous year, weighted by enrollment in each plan.

B. "CoverColorado" is the Colorado program which provides health insurance for those individuals who are termed "high risk" because they are unable to obtain health insurance or are unable to obtain health insurance except at prohibitive rates or with restrictive exclusions. The program is described in §10-8-501 et seq., C.R.S.

C. "Eligible Individual" is either:

1. a resident of this state who meets the eligibility requirements set forth in §10-8-513, C.R.S.; or

2. an individual who meets the eligibility requirements for a federally eligible individual, as set forth in §10-16-105.5(1), C.R.S.

This term does not include the dependents of eligible individuals.

D. "Group health plan" has the same meaning as set forth in §10-16-105.5(1)(a), C.R.S.

E. "Higher level health benefit plan design" means a health plan benefit design for which the actuarial value of the benefits is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of the benefit design weighted average.

F. "Insurer" is any entity that provides group or individual health benefit plans, as that phrase is defined in §10-16-102(21), C.R.S., and is subject to state insurance regulation in this state, as well as any entity, including a property and casualty insurance company, that, directly or indirectly, provides stop loss or excess loss insurance to a self-insured group health plan. The phrase "health benefit plans," as used in this paragraph, shall have the same meaning as set forth in §10-16-102(21), C.R.S.

G. "Lower level health benefit plan design" means a health benefit plan design for which the actuarial value of the benefits is at least eighty-five percent (85%) but not greater than ninety-nine percent (99%) of the benefit design weighted average.

Section 4 Determination of Need for Special Fee Assessment

A. CoverColorado shall, as frequently as shall be deemed necessary by the CoverColorado board, project (i) the cash balance of the CoverColorado cash fund; (ii) the balance of any funds held or invested by the CoverColorado board or the administering carrier; (iii) interest earned on the CoverColorado funds; (iv) premiums received from the enrolled eligible individuals; (v) revenue from the other sources listed in §10-8-530(1), C.R.S.; (vi) payment for claims incurred by enrolled eligible individuals; (vii) a reserve for claims incurred but not reported for enrolled eligible individuals; (viii) administrative expenses for enrolled eligible individuals; (ix) interest on moneys borrowed to defray the claim costs incurred by enrolled eligible individuals; and (x) a surplus amount equal to ten percent (10%) of projected incurred claims for enrolled eligible individuals. The projections shall not include any costs related to any dependent coverage offered by CoverColorado.

B. To the extent that the projected operating revenues, cash balance and funds then currently held or invested by the program will be adequate to provide for projected claims, administrative expenses and the IBNR reserve and surplus, no assessment shall be made to insurers.

C. To the extent that the projected operating revenues, cash balance and funds then currently held or invested by the program are not adequate, the projected deficiency amount shall be the basis for the determination of a per capita assessment of special fees.

D. The CoverColorado board shall obtain no less than two actuarial evaluations (obtained from qualified actuaries as defined in Division of Insurance Regulation 1-1-1) before undertaking the first assessment and before undertaking any increase in the amount of the assessment in any subsequent year.

Section 5 Determination of Amount of Assessment to Each Insurer

A. Commencing on January 15, 2002 and every March 1 thereafter, each insurer shall report to CoverColorado, on the form prescribed, (i) the total number of employees and retired employees or individual policyholders or subscribers enrolled in all of its health benefit plans offered in this state and (ii) the number of employees/retired employees for whom a premium is paid and coverage is provided under an excess loss, stop loss or reinsurance policy issued by such insurer to an employer or group health plan in this state, as of December 31 of the previous year. The totals to be reported shall not include those employees, retired employees or individual policyholders or subscribers who receive health benefits through Medicare, Medicaid

or the Children's Basic Health Plan (pursuant to article 19 of title 26, C.R.S.). CoverColorado shall allow those insurers providing stop loss, excess loss or reinsurance to exclude from their counts those employees/retired employees or individual policyholders/subscribers who have been counted by the primary carrier or the primary reinsurer.

B. The projected deficiency, if any, determined by CoverColorado in accordance with Section 4.C above shall be assessed in an equitable manner upon insurers, as follows:

1. The projected deficiency shall be divided by the total number of employees, retired employees and individual policyholders or subscribers reported by all insurers, to arrive at a per capita amount.

2. The special fee assessed to each insurer shall be equal to the number of employees and retired employees or individual policyholders or subscribers reported in the month of March immediately preceding issuance of the notice multiplied by the per capita amount.

Section 6 Notice and Collection of the Assessed Special Fees

A. Special fees may be assessed as needed by CoverColorado, but in no event more than twice in any calendar year in accordance with this section. As actual claim and administrative expense information is obtained, it will be incorporated into the succeeding projection.

B. Insurers shall receive written notice of the first per capita assessment, as determined in Section 5.B.1 above, if any, on February 1, 2002 and as needed thereafter, subject to section 6.A above. Each notice of an actual assessment, whether on February 1, 2002 or thereafter, shall include (i) the per capita amount, determined as in Section 5.B.1 above; (ii) a calculation of the assessment due and owing (based on the per capita amount multiplied by the number of employees and retired employees or individual policyholders or subscribers reported in the month of March immediately preceding issuance of the notice); and (iii) a summary of the projections and underlying assumptions which support the need for the assessment in general and the per capita amount in particular.

C. Insurers shall pay each assessment of special fees to CoverColorado on the first day of the month thirteen (13) months after issuance of the notice of assessment ("the Due Date") (e.g., the assessment noticed on August 1, 2002 will be due and payable on August 1, 2003). No later than ninety (90) days before a noticed assessment is due, CoverColorado shall send a general reminder of the assessment Due Date to all insurers.

D. CoverColorado, or its designated agent, shall collect all assessed special fees and deposit the fees into the accounts specifically maintained by the CoverColorado board for this purpose. Any amounts not immediately needed to pay the expenses and losses for eligible individuals

shall be invested by the board in accordance with the investment guidelines adopted by the board and filed with the Division of Insurance as part of CoverColorado's plan of operations.

E. If the special fees collected exceed the amount actually needed, the excess shall be invested by the board in accordance with the investment guidelines adopted by the board and filed with the Division of Insurance as a part of CoverColorado's plan of operations and shall, in accordance with Section 4.A. above, be included as funds held by CoverColorado when the next projections are made. Notwithstanding the foregoing, any insurer who has received a deferred status, pursuant to Section 7.A. below, at the time fees are assessed may be entitled to a deferral of the fees, at the discretion of the commissioner.

F. In the event that any insurer fails to pay its special fee as assessed by CoverColorado, CoverColorado shall send one notice of nonpayment thirty (30) days after the Due Date. If CoverColorado has not received payment of all amounts due from an insurer within thirty (30) days after the date of the notice of nonpayment, CoverColorado shall report same to the commissioner.

G. An insurer receiving a certificate of authority to do business in the State of Colorado market on or after the date of issuance by CoverColorado of a notice of assessment shall receive notice of the assessment at the time of licensure and shall be liable for any assessment(s) due and owing in the calendar year following the year in which the certificate of authority was granted, and thereafter in the normal course of the assessment process. Such new insurer shall not be liable for any assessment due and owing in the calendar year in which the certificate of authority is granted.

H. Any insurer withdrawing from the Colorado market shall only be liable for any assessment owing in the calendar year of withdrawal and shall not be liable for any assessment owing thereafter. The date of withdrawal shall be the date on which the last contract or policy of the insurer in Colorado expires, is terminated by the insurer in accordance with Colorado insurance laws or is voluntarily terminated by the policyholder/subscriber, whichever is sooner. Any insurer discontinuing a type of health coverage (e.g., small group coverage) in the Colorado market shall be liable in the calendar year of discontinuation for any assessment due and owing in that calendar year, and the amount of assessment due and owing shall be calculated pursuant to section 6.B., regardless of any reduction in the number of employees and retired employees or individual policyholders or subscribers in that calendar year by reason of the discontinuation.

Section 7 Deferral of or Credit Against Special Fees

A. Any insurer that believes that the payment of special fees would endanger its financial ability to fulfill its contractual obligations to its insureds may submit, no later than one hundred twenty (120) days before an assessment is due and owing (i.e., 120 days before the Due Date), a

written request for deferral of its payment of its assessed special fees to the commissioner, with a copy sent to CoverColorado. The written request for deferral shall be accompanied by certified copies of statutory annual and quarterly statements and any other documents necessary to demonstrate the claimed adverse financial position. Based on the Division of Insurance's risk-based capital guidelines, the commissioner may defer, in whole or in part, payment of the special fees owing on the Due Date in the calendar year in which the request is made. The commissioner's determination regarding deferral shall be made within thirty (30) days of receipt of a written request for deferral, with written notice of the determination sent to CoverColorado. The insurer receiving the deferment shall remain liable to CoverColorado for the deferred amount, and the deferred amount shall be incrementally reassessed to the insurer over such period as is deemed reasonable by CoverColorado, in consultation with the commissioner and the insurer, but in no event longer than three (3) years.

B. In the event a special fee assessed against an insurer is deferred, in whole or in part, the amount by which the special fee is deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in Section 5 above (the resulting additional special fees shall be called "excess special fees"). Written notice of excess special fees shall be sent to all insurers no later than sixty (60) days prior to the Due Date. Such excess special fees amount shall be included by the insurer in its payment of previously assessed special fees to CoverColorado on the Due Date. As the deferred assessment is repaid in subsequent assessments by the deferring insurer, as provided in subsection 7.A above, each insurer that paid such excess special fees shall receive a pro rata credit for its share of previously paid excess special fees.

C. An insurer shall be entitled to a credit, in the amount set forth in 7.D below, against special fees assessed (exclusive of excess special fees) if it meets any of the following criteria and has enrolled the required number of individuals in the health benefit plans described during the previous twelve-month period:

1. Any insurer that voluntarily and actively markets and offers, continuously over the twelve-month period preceding the calendar year in which an assessment is due and owing, two different individual health benefit plans to an applicant who has a medical condition on the presumptive conditions list maintained by the CoverColorado board, with the premium for such plans no higher than 125% of the rate charged for a similarly situated (considering age and geographic location) but medically acceptable applicant. The two different plans shall be either:

a. The two plans that are generally available and actively marketed to the public and are the plans with the largest and next to largest premium volume of all individual health benefit plans offered by the insurer in this state; or

b. A lower level health benefit plan design and a higher level benefit plan design, both of which include benefits similar to other individual health benefit plans offered in the state.

2. Any insurer that voluntarily and actively offers, continuously over the twelve-month period preceding the calendar year in which an assessment is due and owing, two different small group health benefit plans to an applicant who is a business group of one under all of the following conditions: (i) outside of the open enrollment periods established by §10-16-105(7.3)(i), C.R.S.; and (ii) without regard to the health status of the applicant or any dependents. The two different plans shall meet either of the criteria set forth in Paragraphs 7.C.1(a) and (b) above, except that the two plans are those offered by the insurer to small groups, including business groups of one, in Colorado.

3. Any insurer that voluntarily and actively offers, continuously over the twelve-month period preceding the calendar year in which an assessment is due and owing, two different individual conversion health benefit plans to an applicant, (i) without regard to the health status of the applicant; and (ii) at a premium rate that is 10% or more below the CoverColorado rate for a similarly situated individual (considering age, sex, smoking status and geographic location). The two different plans shall meet one of the criteria set forth in Paragraphs 7.C.1(a) and (b) above.

D. Under any of the criteria in Paragraphs 7.C.1, 7.C.2 or 7.C.3 above, the insurer shall be entitled to a credit against any assessment due and owing in a calendar year equal to three percent (3%) for enrolling the following number of individuals in the above-described plans during the preceding twelve-month period:

1. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado (pursuant to Section 5.A above) is 25,000 or less, 25 individuals;

2. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado is more than 25, 000, but less than 75,000, 50 individuals; or

3. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado is 75,000 or more, 100 individuals.

E. Any insurer that believes that it is entitled to a credit shall submit a written request for credit, along with supporting documentation satisfactory to the commissioner, of compliance

with Paragraph 7.C.1, 7.C.2 or 7.C.3 above no later than one hundred twenty (120) days before any assessment is due and owing (i.e., 120 days before any Due Date).

F. The commissioner shall make a determination regarding a credit within sixty (60) days of submission of a written request. All credits will be reported by the commissioner to CoverColorado.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 9 Effective Date

This Amended Regulation shall become effective on July 1, 2002.

Section 10 History

New regulation effective on January 1, 2002.
Amended, effective July 1, 2002.

① keep in 149

②

fn drafting → add the 3 req. — have bd do it on basis of ↖

& consider MA data — (for market share)

as basis fn allocating assessment

one place to look

③ gov appts bd members

~~[illegible]~~

but ½ if senate must confirm gov appt, then

don't have gov appt

(don't change fn now)

at all

could try to make stop loss stuff more like drug stuff

bd determine methodology